



**Patient Information**

Name: \_\_\_\_\_

Date of Birth (Month/Day/Year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Gender: M or F

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Date of Birth (Month/Day/Year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Father's name: \_\_\_\_\_

Date of Birth (Month/Day/Year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Emergency Contact (other than parents)**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone: \_\_\_\_\_



## Consent

I hereby authorize Optimum Medical, LLC to disclose my protected health information to carry out, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review the practice's notice of privacy for a more complete description of uses of disclosure before signing this consent.

I understand that Optimum Medical, LLC, has the right to change their privacy practices and that I may obtain any revised notice at the practice, Optimum Medical, LLC

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow my restrictions.

I understand that I may revoke this consent at any time, by making request in writing, except for information already used or disclosed

---

Optimum Medical, LLC is pleased to be in network with the insurance carriers.. If we are not in network with your primary insurance provider, Optimum Medical, LLC will submit detailed claims of our services directly to the insurance on file on the patient's behalf. However, please remember that insurance is not a substitute for payment. It is your responsibility to pay any copayments and deductibles required by your insurance policy, as well as any balance not covered under your insurance policy. We are required to charge you for any balance not covered by your policy, and we will forward the necessary invoices to you after your account has been reconciled by your insurance company.

I authorize release of any medical information necessary to determine liability for payment and to allow Optimum Medical LLC to obtain reimbursement of any claim. I request that payment of authorized benefits be made in my child's name. I attribute benefits to pay medical and/or surgical benefits, including major medical benefits, private insurance, and other reimbursements. This document will remain in effect until revoked by me in writing. A scanned copy of this document shall be considered a valid original. I understand that I am financially responsible for all charges, whether or not paid by any insurance policy. I hereby authorize Optimum Medical, LLC to release all information necessary to secure such payment.

---

Printed Name of Parent

Signature

Date



Optimum Medical, LLC  
Jacques Etienne M.D., F.A.A.P  
48 Main St Danbury, CT 06810  
Phone: (203) 794-9000 Fax: (203) 794-9005